DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	00	COMPL	
		155781	B. WIN	G		11/30/	2012
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			915 S 2	7 ST		
		G AND MEMORY CARE CENTER		SOUTH	BEND, IN 46615		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
			F00	00			
	This wisit was for	m the Investigation of	1.00	00			
		r the Investigation of					
	*	118500. This visit					
	resulted in a part						
	survey-Substand	ard Quality of Care.					
	Complaint IN00	118500-Substantiated.					
	_	related to the allegations					
	are cited.	related to the allegations					
	are cited.						
	Unrelated deficie	ency cited.					
	Survey date: Nov	vember 29, 2012					
		date: November 30,					
	2012	date. Tvo vember 50,					
	2012						
	Facility number:	012199					
	Provider number						
	AIM number: 20						
	Survey team:						
	Janet Adams, RN	N					
		•					
	Census bed type:	:					
	SNF: 12	-					
	SNF/NF: 8						
	Total: 20						
	101.1. 20						
	Census payor typ	pe:					
	Medicare: 2						
	Medicaid: 8						
	Other: 10						
	Jule1. 10						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155781	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	ie survey ipleted 30/2012
	PROVIDER OR SUPPLIE	R IG AND MEMORY CARE CENTE	915 S 2	ADDRESS, CITY, STATE, ZII 7 ST BEND, IN 46615	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	Sample: 6					
		reflects state findings nnce with 410 IAC 16.2.				
	Quality review co 2012 by Janelyn	ompleted on December 6, Kulik, RN				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9ZYK11

Facility ID: 012199

If continuation sheet

Page 2 of 8

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: A. BUILDING		DING	00		COMPLETED	
		155781	B. WIN			11/30/	2012	
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			915 S 2				
MORNINGCREST NURSING AND MEMORY CARE CENTER					H BEND, IN 46615			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0323	483.25(h)	TNIT						
SS=F	FREE OF ACCID	ENT RVISION/DEVICES						
		ensure that the resident						
	•	ains as free of accident						
		sible; and each resident						
	•	e supervision and						
	assistance device	es to prevent accidents.						
			F03	23	There were no residents affect	ted	12/01/2012	
	Based on observ	ation, record review, and			by the elevated water			
		cility failed to ensure the			temperatures. All staff were			
		ment remained free of			informed of the elevated			
		quate supervision was			temperatures and were instruct to monitor resident bathrooms			
					and the shower room to ensur			
	•	to water temperatures			residents would not use the wa			
	•	ed 100-120 degrees			unattended. After further			
		s. The facility also failed			adjustment of the valve on the			
		ter temperatures were			water heater, the temperature			
	monitored on a r	outine basis and after			the water was within the require			
	observations of e	elevated water			100-120 degrees fahrenheit. A inservice was held on 11/30 to			
	temperatures. Th	is deficient practice had			review water temperatures. S			
	the potential to a	ffect 20 of 20 residents			were instructed on how to mor			
	residing in the fa	cility.			water temperatures including			
	(Residents #B, #	#C, #D, #E, #F, #G, #H,			procedures to follow if			
	#J, #K, #L, #M,	#N, #P, #Q, #R, #S, #T,			temperatures were not within trequired range. The Maintenan			
	#U, #V, and #W				Supervisor was intsructed to ta			
	, ,	,			daily temperatures to ensure			
	Findings include				temperatures remained within	the		
	i manigs merade	•			required range. The mixing			
	On 11/20/12 at	10:00 a m the vester			valve on the water heater was			
		10:00 a.m., the water			replaced on 12/6/2012. Water			
	•	resident's room were			temperatures were adjusted a remained within the required	iiu		
		e facility Administrator.			range. Water temperatures wil	l be		
	The water tempe	eratures were as follows:			taken and recorded daily by th			
	Room 101: 122.	4 degrees Fahrenheit			Maintenance Supervisor or			
					designee for two weeks to ens	ure		
	Room 102: 123.	4 degrees Fahrenheit			proper temperatures. The			
					Administrator will review the w	ater		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9ZYK11

Facility ID: 012199

If continuation sheet Page 3 of 8

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MU			ULTIPLE CO	ONSTRUCTION	(X3) DATE :	SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. BUILDING 00			COMPLETED	
		155781	B. WIN			11/30/	2012
			ı	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	£		915 S 2	7 ST		
	GCREST NURSING	G AND MEMORY CARE CENTER	_	SOUTH	I BEND, IN 46615		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		_	DATE
					temperature logs daily to verify temperatures are within the	/	
		104 (shared bathroom):			required range and those resu	lts	
	124.9 degrees Fa	ahrenheit			will be reported to and reviewe		
					weekly by the Quality Assuran	ce	
	Rooms 105 and	106 (shared bathroom):			team. Once the Quality		
	125.4 degrees Fa	ahrenheit			Assurance team determines the	ie	
					temperatures are within the required range for two weeks,		
	Rooms 108 and	109 (shared bathroom):			then the temperatures will be		
	121.4 degrees Fa	,	1		taken and recorded weekly.Th	е	
					Quality Assurance team will		
	Rooms 110 and	111 (shared bathroom):			review the water temperature I	•	
	124.8 degrees Fa				during the quarterly meeting to		
	124.0 degrees 1 8	incinci			ensure the temperatures are in range and taken consistently of		
	The facility West	on Tommonotumo loga vivono			weekly basis. The Quality	ni u	
		er Temperature logs were			Assurance team will then decide	de	
		r temperatures were			whether on-gong monitoring fr	om	
	recorded on the	following dates:			the team is required. The		
	9/4/12				Maintenance Supervisor or designee will take water		
	9/11/12				temperatures and record them	on	
	9/17/12				a weekly basis to ensure they		
	9/24/12				within the required range. The		
	10/1/12				Administrator will review the lo	gs	
	10/8/12				weekly to ensure water		
	10/15/12				temperatures are taken and recorded as well as remain wit	hin	
	10/22/12				the required range of 100-120		
	11/16/12- only to	emperatures recorded			degrees Fahrenheit. Monitorin	g of	
	were for the pub	lic restroom, shower, and			the water temperature logs is		
	kitchen. The tem	peratures recorded for			on-going. The Maintenance		
	the above were a	1			Supervisor and Administrator a responsible to monitor to ensu		
		- 122.0, Kitchen 115.1,			compliance.		
	and Shower: 122				,		
	and 5110 W C1. 122	0					
	11/16/12- reched	ck recorded as follows:					
	Room 104- 115.	7 degrees Fahrenheit					
		2 degrees Fahrenheit					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9ZYK11

Facility ID: 012199

If continuation sheet Page 4 of 8

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY	
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPL	ETED
		155781	B. WIN			11/30/	2012
NAME OF I	DROVIDED OD GUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF			915 S 2	7 ST		
		G AND MEMORY CARE CENTER			BEND, IN 46615		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		2 degrees Fahrenheit					
		- 116 degrees Fahrenheit					
		degrees Fahrenheit					
	Room 112- 118	degrees Fahrenheit					
	Kitchen- 115.1	degrees Fahrenheit					
	No further water	temperatures were					
	recorded betwee	n 11/17/12 and 11/29/12.					
	The policy titled	l "Maintenance					
		reviewed on 11/29/12 at					
		ere was no date on the					
		icy was received from the					
		trator and identified as					
	*	licy indicated the					
	_	-					
		rector was responsible for					
		maintaining a schedule of					
		vices to assure the					
		ds, and equipment were					
	maintained in a	safe manner.					
	The policy titled	"Maintenance Policy"					
		n 11/29/12 at 11:15 a.m.					
		te on the policy. The					
		ved from the facility					
	1 ^ -	nd identified as current.					
		ated water temperatures					
		ured and recorded to					
	I -	ot exceed 120 degrees					
	Fahrenheit.						
	When interview	ed on 11/29/12 at 10:05					
		Administrator indicated					
	'	ater temperature felt					
		•					
	eievated on 11/2	8/12 when she used the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9ZYK11

Facility ID: 012199

If continuation sheet Page 5 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155781	B. WIN	G		11/30/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				915 S 2			
MORNIN	GCREST NURSING	AND MEMORY CARE CENTER		SOUTH	BEND, IN 46615		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		lic bathroom. The					
		dicated she did not take					
	Administrator in	dicated she checked the					
	water tank and th	ne temperature "was					
	above the line" v	which meant it was higher					
	then required and	d she turned the					
	temperature dow	n at that time.					
	When interviewe	ed on 11/29/12 at 10:20					
	a.m., the facility	Administrator indicated					
	approximately a	week or two ago on					
		I noticed the water was					
	hot to touch and	notified the Maintenance					
	•						
		•					
		-					
	-	-					
		•					
	•						
	water temperatur	res.					
		nance Supervisor					
	indicated he had	been working at the					
	facility for appro	eximately three weeks.					
	The Maintenance	e Supervisor indicated he					
	any water tempe Administrator in water tank and the above the line" withen required and temperature down when interviewed a.m., the facility approximately a 11/16/12 she had hot to touch and Supervisor. The she did not take that time. The Administration to the facility the initially high and Supervisor adjust reported the probability of the Administrative any water to time. The Administrative any water to the facility the initially high and Supervisor adjust reported the probability of the Administrative any water to time. The Administrative water temperature water temperature water temperature water temperature indicated he had facility for approximately and the supervisor and the supervisor adjust and the sup	ratures at that time. The dicated she checked the me temperature "was which meant it was higher d she turned the mat that time. ed on 11/29/12 at 10:20 Administrator indicated week or two ago on a noticed the water was notified the Maintenance Administrator indicated any water temperatures at administrator indicated any water temperatures were at the Maintenance temperatures were at the Maintenance at the Ma					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9ZYK11

Facility ID: 012199

If continuation sheet Page 6 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 11/30/	ETED
		100701	B. WIN		ADDRESS STATE STATE STATES	1 17007	2012
NAME OF P	PROVIDER OR SUPPLIER	L Comment		915 S 2	ADDRESS, CITY, STATE, ZIP CODE		
MORNIN	GCREST NURSING	G AND MEMORY CARE CENTER	!		BEND, IN 46615		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	e Administrator a few					
	_	was reported to him the					
	•	res were elevated. He					
		ne to the facility on that					
	day and and chec						
	•	d one temperature was					
		9 degrees Fahrenheit. He					
		cked temperatures in all					
		ns at that time and the					
		ure he could recall in a					
		degrees Fahrenheit. The					
	_	pervisor indicated he did					
		ment in the basement and					
		down to lower the water					
	-	indicated he rechecked					
	-	after the adjustment and					
	-	ratures were between 115					
	- 118 degrees Fa	pervisor indicated he had					
		water temperatures at					
	this facility since	*					
		pervisor also indicated					
	_	inistrator called him					
	•						
		ported the temperatures ne had turned down the					
	_	indicated he was at the					
	_	/12 due to a power outage					
	and he did not ch						
		n. The Maintenance					
	-	ated water temperatures					
	_	be checked once a week					
	_	completed between					
	10/22/12 and 11/	-					
	10/22/12 and 11/	10/14.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9ZYK11

Facility ID: 012199

If continuation sheet

Page 7 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155781	A. BUILDING B. WING	00	COMPLETED 11/30/2012
MORNIN		G AND MEMORY CARE CENTER	915 S 2 SOUTH	ADDRESS, CITY, STATE, ZIP CODE 27 ST 1 BEND, IN 46615	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
I				DEFICIENCY)	AIE .

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9ZYK11

Facility ID: 012199

If continuation sheet Page 8 of 8